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ABSTRACT

This paper reviews information regarding the incidence, demographic characteristics, family characteristics, and immediate/ongoing characteristics of incest victims. The characteristics reported include behavioral indicators of abuse, such as acting-out behavior, self-destructive behaviors, and provocative and inappropriate sexual behaviors; psychological disorders such as depression, suicide attempts, phobias, and compulsions; school-related behaviors such as truancy or underachievement; and physical symptoms. The common features of these behaviors and symptoms are discussed. A final section addresses the role of the school psychologist in prevention, identification, intervention, treatment, and child advocacy for victims of incestuous abuse. It is recommended that the role of child advocate in child sexual abuse cases should involve monitoring the effects of legal intervention on the child, and organizing community support groups. References are included. (TE)

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Intrafamilial Child Sexual Abuse

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Abstract

The present article presents information regarding the incidence and demographic characteristics, family characteristics and the immediate/ongoing characteristics of incest victims. The characteristics reported include behavioral and psychological indicators of abuse, and represent a compilation of previous research as well as previously unreported findings. A final section involves the role of the school psychologist in terms of prevention, identification, intervention, treatment and child advocacy in the area of incestuous abuse.

Intrafamilial Child Sexual Abuse

Incest is a topic generally associated with two of society's strongest taboos - the invasion of family privacy and child sexual abuse. Legal requirements regarding the reporting of incest have improved over the past few years but social and professional attitudes and information continue to neglect this important area of child abuse (K. D. Cooper, 1979; McIntyre, 1981). As in many other areas of child abuse, school psychologists are in a position to play particularly important roles in prevention, intervention and child advocacy.

The present article will review pertinent data including incidence and demographic characteristics, family characteristics and the immediate/ongoing characteristics of incest victims. Finally, a brief summary will be included regarding the role of the school psychologists.

Incidence

Perhaps one of the most contradictory findings associated with intrafamilial sexual abuse concerns the actual incidence of its occurence. Weinberg (1955, 1976) estimated the incidence of incest as one in a million, while more recently researchers estimate that incest actually occurs in one out of every ten families (Burgess,

Groth, Holmstrom, & Sgroi, 1978). Finkelhor (1984) estimated that for every one case of reported incest, four go unreported. Regardless of the reported incidence, it is generally accepted that incest occurs more frequently than was once thought (Kempe & Kempe, 1984). A number of factors account for the varying incidence reports. Sagarin (1977) indicated that the legal system and the sanctity and collusiveness of the family unit have been major contributors to the problem of underreporting cases of incest and therefore the lack of a true incidence estimate. While these factors have typically resulted in lower incidence rates than researchers suspect, other factors have led to increased reports. Some of these advances include mandatory reporting laws, organizations which continue to lobby for stronger legal sanctions, professionals willing to research and publicly address the issue and a growing number of treatment centers which specialize in child sex abuse.

Demographic Influences

Incest occurs across all social and ethnic classes, a range of educational and intellectual achievements, and with persons demonstrating seemingly adequate social adjustment (Finkelhor, 1979; Sagarin, 1977; Specktor, 1979).

Approximately 98% of reported incest offenders are male and 80% to 90% of the victims are female (Brassard, Tyler, & Kehle, 1983). Incest is generally initiated (covert or overt) when the child is between four and twelve years of age (Gelinas, 1983). Approximately three-quarters of reported incest offenses involve father-figure daughter activities (Peters, 1976).

Family Characteristics

Characteristics associated with the family appear to be the most widely accepted explanation for the occurrence of incestuous activity. This family structure is often referred to as a dysfunctional family system or character disordered family. This position incorporates the idea that there are three members in the incest relationship: the offender (father-figure), the victim (child), and the non-participatory collusive member (the mother). The incestuous family members have broken down boundaries existing between parent and child and have essentially reversed roles (Anderson & Shafer, 1979). The child has been given the role of provider and caretaker of the parents (physically and emotionally) (Cohen, 1983; Randolph, 1987). These families are father-dominated in almost every area of their functioning (Lustig & others, 1976). The fathers typically isolate the family members from outside influences and controls the economics and social relationships of

family members (Dietz & Craft, 1980). Others have stressed the physically as well as sexually violent nature of this family--perhaps as a way to intimidate and dominate the family members (Browning & Boatman, 1977; Randolph, 1987). Typically, the mother and children in the incestous home adopt passive, helpless and submissive roles to the father's domination (Dietz & Craft, 1980), and mothers may be absent from the home for an extended period of time (Finkelhor, 1979).

Briefly, both the mother and father in the incestuous family may have childhood histories of abuse (physical, sexual), rejecting parents and institutionalization (de Young, 1982; Gebhard, Gagnon, Pomeron, & Christenson, 1965; Meiselman, 1978). This background may predispose these individuals to poor parenting skills, insecurity with interpersonal relationships, poor self-concept and extreme dependency.

The victim and ongoing-immediate effects of abuse

Although many studies concerning incestuous effects have yielded contradictory findings, others have reported consistent results across samples and have provided useful information concerning the incest victim and the effects.

The victim, in most cases, is the eldest daughter in the family. However, the father typically "moves on" to the next child

as one abusive relationship is terminated. She is average in intelligence, although performs below average in school (Meiselman, 1978). The victim does not appear to have any distinguishing characteristics prior to the incestuous abuse.

Incest victims typically display a range of symptoms or characteristics as the incestuous abuse is ongoing. Victims may display behavioral, sexual, psychological, physical, and psychosomatic symptoms.

Behavioral symptoms frequently associated with incest victimizaiton include acting-out behavior and self destructive behaviors. Victims of incest display a number of acting out behaviors, including running away (three times more common in incest versus non-incest groups), school truancy, poor school performance, and juvenile delinquent acts (Finkelhor, 1979; Gordy, 1983; James, 1975; Randolph, 1987; Silbert & Pines, 1983). Incest victims also demonstrate a variety of self-destructive behaviors (de Young, 1981; Gordy, 1983; Kempe & Kempe, 1984; Randolph, 1987). Self-destructive acts associated with incest include suicide attempts, drug/alcohol abuse and self-injurous acts (i.e. cutting one's face, body, genital area, breaking bones). The acting out behaviors and self-destructive tendency can be viewed as a way of punishing themselves for perceived guilt, a means of avoiding the

activity, as inadequate coping mechanisms, or simply as a way of calling attention to themselves in an efffort to receive help.

Provocative and inappropriate sexual behaviors towards others (adults and children) and self (masturbation) have been reported as behaviors seen in incest victims (Browning & Boatman, 1977; Yates, 1982). This behavior is not seen as seductive but rather as an attempt by the child to seek affection and/or attention the only way they know how, or as a way to indirectly reveal the sexual abuse. Some children will display and discuss sexual knowledge beyond their years. Sexual acting out (or promiscuity) has also been proposed as an after effect of incest and a symptom of sexual victimization (Lukianowicz, 1972; Silbert & Pines, 1983). However, others have noted that reports of promiscuity have been over emphasized; the percentage of this effect is generally low in the overall samples and research reporting this effect appear biased for this result (i.e. use of juvenile centers, police records). So, although the effect of promiscuity was reported in some studies, it does not appear to be a conclusive finding (Meiselman, 1978; Randolph, 1987). The issue of revictimization has been reported and implies that child victims of sexual abuse are likely to be revictimized as children and adults (Browne & Finkelhor, 1986).

Psychological disorders have also been reported in a number of the studies on incest abuse. Incest victims are more likely to report seeking psychological services (Randolph, 1987). Among the more frequently reported psychologiccal problems associated with incest are depression, suicide attempts, phobias, and complusions (Molnar & Cameron, 1975). Character disorders, psychosomatic complaints, neurotic symptomology, anti-social tendancies and psychotic complaints have also been reported to a lesser extent in the research literature (Lukianowicz, 1972; Maisch, 1973; Meiselman, 1978). Findings concerning psychological disorders should be viewed cautiously. However, professionals working with children should be aware that incestuous abuse could be a contribution to psychological complaints.

School related behaviors include, truancy or a refusal to attend school, staying at school longer than necessary (arriving early, staying late), a drop in grades, not achieving commensurate with abilities and an unwillingness to participate in certain school activities (e.g. physical education) (Caterino, 1987).

Short-term (ongoing) effects of incest also include a number of physical symptoms. The more obvious effects include pregnancy and sexually communicated diseases (Brant & Tisza, 1977). Others have reported such symptoms as abdominal pains, enuresis, sleeping

disorders, eating disorders, stomach aches, painful urination, urinary tract infections and genital irritation (Brant & Tisza, 1977; Kempe & Kempe, 1984). Other physical signs of sexual abuse include difficulty walking or sitting, genital itching, bleeding, or discharge, bloody or torn undergarments and bruises. Physicians and psychologists have reported a number of hysterical symptoms associated with incestous experiences including, paralysis, malingering, and epileptic seizures (Goodwin, Simms, & Bergman, 1979; Gross, 1979; Kempe & Kempe, 1984; Remich & Wada, 1979).

Since the victim has assumed a "special " role in the family, she has generally become isolated from the mother and sibling(s) within the home and because of the father's control, also isolated from outside influences. This isolation and rejection persists upon disclosure and leads to increased feelings of anxiety and worthlessness, especially if she is removed from the home upon disclosure (de Young, 1981; Herman & Hirschman, 1977) Researchers have also documented the feelings of guilt and low self-esteem experienced upon disclosure (both from disclosure of the incestuous abuse and the disruption of the family) (de Young, 1982). Peters (1976) indicated the immediate reaction of the victim may be described as "brazen poise". He notes that this behavior is often a product of the pseudo-mature roles they have assumed, but should

be seen as an inability to express a reaction openly or a emotional withdrawal. Therefore, the child's initial behaviors should not be seen as evidence that no harm has occurred as a result of the experience.

Many of the preceding behaviors and symptoms have several common features. First, they serve as escape behaviors removing the victim from the home (and the offender). Secondly, they place the victim in a position to expose the incest to outsiders in a nondirect manner (i.e. to school personnel, social workers, police, or physicians). This suggests that the victim is not as passive or participatory concerning the continuation of the relationship, rather, it would appear that the child is attempting to end the experience and/or seek help in the only manner available to him/her.

The role of the school psychologist

School psychology is in a position to play an important role in the prevention, identification, intervention, treatment and child advocacy in the area of incestuous abuse.

In the area of prevention, school psychologists can provide workshops/inservices for community groups, parents, school personnel and children. These educational programs should include information regarding strategies that adults can teach children in

order to prevent sexual abuse, symptoms that can be used to diagnose sexual abuse and agencies or contact persons within the community which provide intervention, treatment and support for victims and families. Several well developed (and adaptable) programs are currently available for professionals involved in preventive service delivery (Adams & Fay, 1981; S. Cooper, Y. Lutter, & C. Phelps, 1983; Kent, 1979). Media supplies for presentation to parents, schools and community groups are also available and recommended to supplement discussions (Erickson, Mc Envoy, & Colucci, 1984). Not all school psychologist will feel confortable presenting materials and discussing the issue of child sexual abuse; in these cases, it is recommended that outside consultants be contacted for program presentations.

In order to provide services for this often neglected population of child abuse victims, they must first be identified. School psychologists must educate themselves regarding high risk family characteristics, high risk children/adolescents, symptoms or characteristics associated with abuse and techniques used to assess child sexual abuse (Brassard et al., 1983; Caterino, 1987).

Mandatory reporting laws require individuals to report suspected cases of child sexual abuse. So, due to the seriousness of the offense, the collusiveness and isolation of the family and

legal mandates, intervention is generally the role for legal authorities and child protection agencies. School psychologists should however follow-up on reported cases of incest in order to assure immediate action and if needed, assume the role of child advocate.

The role of child advocate in child sexual abuse cases should involve monitoring the proccess of intervention in order to determine if the child's rights are being observed as well as to monitor the effects of intervention on the child. The child advocacy role may also involve organizing community support groups in an effort to lobby for appropriate legislation and expanded services for incest victims.

Finally, the area of treatment for incest victims may pose a role that many school psychologists feel inadequate to address. They should however be aware of public and private treatment facilities and support groups within their community which offer services for incest victims and family members.

Due to the work setting, role and function and client population, school psychologists could be the professionals who provide much needed services to this often neglected population of child sexual abuse victims. This goal can be reached if school psychologists educate themselves regarding high risk families and

children, symptoms of abuse, the need for preventive euducation and improved intervention and treatment programs. Finally, the school psychologist must recognize that any child can be a victim of abuse and that the school setting may provide the incest victim with his/her only source of outside contacts and intervention.

References

Adams, C., & Fay, J. (1981). No more secrets: Protecting your child from sexual assault. San Luis Obispo, CA: Impact.

Anderson, L. M., & Shafer, G. (1979). The character disordered family: A community treatment model for family sexual abuse. American Journal of Orthopsychiatry, 49, 436-445.

Brant, R. S. T., & Tisza, V. B. (1977). The sexually misused child. American Journal of Orthopsychiatry, 47, 80-90.

Brassard, M. R., Tyler, A., & Kehle, R. J. (1983). Sexually abused children: Identification and suggestions for intervention. School Psychology Review, 19, 93-97.

Browne, A. B., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. Psychological Bulletin, 99, 66-77.

Browning, D. H., & Boatman, B. (1977). Incest: Children at risk. American Journal of Psychiatry, 134, 67-72.

Burgess, A., Groth, N., Holmstrom, L., & Sgroi, S. (1978). Sexual assault of children and adolescents. Lexington, MA: Lexington Books.

Caterino, L. C. (1987). Children and sexual abuse. In A. Thomas, & J. Grimes (Eds.), Children's needs: Psychological perspectives. Washington, DC: National Association of School Psychologists.

Cohen, T. (1983). The incestuous family revisited. Social Casework, 64, 151-161.

Cooper, K. D. (1979). Incest in today's society: An orientation for graduate students in the helping professions. Unpublished doctoral dissertation, University of South Carolina.

Cooper, S., Lutter, Y., & Phelps, C. (1983). Strategies for free children. Columbus, OH: Child Assault Prevention Project.

de Young, M. (1981). Incest victims and offenders: Myths and realities. Journal of Psychosocial Nursing and Mental Health Services, 19, 37-39.

de Young, M. (1982). The sexual victimization of children. Jefferson, NC: McFarland and Company, Inc.

Dietz, C., & Craft, J. L. (1980). Family dynamics of incest: A new perspective. Social Casework, 61, 602-609.

Erickson, E., Mc Envoy, A., & Colucci, N. (1984). Child abuse and neglect: A guidebook for education and community leaders. Holmes Beach, FL: Learning Publications.

Finkelhor, D. (1979). Sexually victimized children. New York: Free Press.

Finkelhor, D. (1984). Child sexual abuse. New York, NY: Free Press.

Gebhard, P. H., Gagnon, J. H., Pomeron, W. B., & Christenson, C. V. (1965). Sex Offenders: An Analysis of Types. New York, NY: Harper & Row Publishers.

Gelinas, D. J. (1983). The persisting negative effects of incest. Psychiatry, 46, 312-332.

Goodwin, J., Simms, M., & Bergman, R. (1979). Hysterical seizures: A sequel to incest. American Journal of Orthopsychiatry, 49, 699-703.

Gordy, P. L. (1983). Group work that supports adult victims of childhood incest. Social Casework, 64, 300-307.

Gross, M. (1979). Incestous rape: A case for hysterical seizures in 4 adolescent girls. American Journal of Orthopsychiatry, 49, 704-709.

Herman, J., & Hirschman, L. (1977). Father-daughter incest. Journal of Women in Culture and Society, 2, 735-756.

James, H. (1975). The little victims: How America treats its children. New York: David McKay Company, Inc.

Kempe, R. S., & Kempe, C. H. (1984). A common secret: Sexual abuse of children and adolescents. R. C. Atkinson, G. Lindzey, and R. F. Thompson (eds.). New York: W. H. Freeman and Company.

Kent, C. (1979). Child sexual abuse project: An educational program for children. Minneapolis, MN: Hennepin County Attorney's Office Sexual Assault Services.

Lukianowicz, N. (1972). Incest. British Journal of Psychiatry, 120, 301-313.

Lustig, N., & others. (1976). Incest: A family group survival pattern. Archives of General Psychiatry, 14, 31-40.

Maisch, H. (1973). Incest. London: Andre Deutsch Limited.

McIntyre, K. (1981). Role of mothers in father-daughter incest: A feminist analysis. Social Worker, 26, 462-466.

Meiselman, K. C. (1978). Incest: A psychological study of causes and effects with treatment recommendations. London: Josey-Bass Publishers.

Molnar, G., & Cameron, P. (1975). Incest syndrome: Observations in a general hospital psychiatric unit. Canadian Psychiatric Association Journal, 20, 373-377.

Peters, J. J. (1976). Children who are victims of sexual assault and the psychology of offenders. American Journal of Psychotherapy, 30, 398-421.

Randolph, M. K. (1987). Long term consequences of father-daughter incest. Unpublished doctoral dissertation, University of South Carolina.

Remich, R., & Wada, J. A. (1979). Complex partial and pseudoseizures disorders. American Journal of Psychology, 136, 320-323.

Sagarin, E. (1977). Incest: Problems of definition and frequency. The Journal of Sex Research, 13, 126-135.

Silbert, M. H., & Pines, A. M. (1983). Early sexual exploitation as an influence in prostitution. Social Work, 28, 285-289.

Specktor, P. (1979). Incest: Confronting the silent crime. Minneapolic, MN: Program for victims of sexual abuse.

Weinberg, S. K. (1955, 1976). Incest Behavior. New York: Citadel Press.

Yates, A. (1982). Children eroticized by incest. American Journal of Psychiatry, 139, 482-485.